STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00116933. Complaint IN00116933-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F323, and F323. Survey dates: October 5, 9, 2012 Facility number: 000184 Provider number: 155286 AIM number: 100267210 Survey team: Ann Armey, RN Census bed type: SNF/NF: 49 Total: 49 Census payor type: Medicare: 6 Medicaid: 35 Other: 8 Total: 49 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.Requesting Desk Review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review 10/12/12 by Suzanne Williams, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interviews and record review, the facility failed to follow the physician's order to discontinue a medication. This deficiency affected 1 of 4 residents, whose medications were reviewed in a sample of 4. (Resident #E) Findings include: The clinical record of Resident #E was reviewed on 10/9/12 at 12:40 p.m., and indicated the resident was hospitalized on 7/12/12 and returned to the facility on 7/22/12, with diagnoses which included, but were not limited to, pneumonia, chronic kidney disease and atrial fibrillation. Nursing Notes, dated 8/30/12 at 10:38 a.m., indicated the resident's blood pressure medications were held because his blood pressure and heart rate were low. The note indicated the physician was notified. Physician orders, dated 8/31/12,	F0282	1. The doctor was notified of said medication error upon discovery with no new orders obtained.2. No other residents were affected. All other residents had the potential to be affected. All other medication records were reviewed to ensure compliance.3. The nurse in question was educated on 9/17/12 by the DNS on following physician orders. All other nurses were educated on 10/9/12 by the DNS on following physician orders. The DNS or designee will conduct chart audits to monitor and to ensure physician orders are implemented.4. The DNS/Designee will monitor all physician orders to ensure compliance daily x 4 weeks then weekly x 4 weeks, then monthly thereafter for at least 6 m onths. If 95% threashold is not achieved an action plan will be developed.5. Completion Date: 10/24/12	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated "D/C (Discontinue) Amiodarone (a medication used to regulate the heart rate)." The September 2012 MAR (Medication Administration Record) indicated the Amiodarone was given for ten days, after it had been discontinued, on 9/1/12 through 9/10/12. The Vital Sign Record indicated the resident's heart rates between 9/1/12 through 9/10/12, were as follows: 9/1/12, 50 beats per minute, 9/2/12, 50 beats per minute, 9/3/12, 72 beats per minute, 9/5/12, 52 beats per minute, 9/6/12, 50 beats per minute, 9/8/12, 50 beats per minute, 9/9/12, 66 beats per minute, and 9/10/12, 50 beats per minute. On 10/9/12 at 1:00 p.m., the DON (Director of Nursing) indicated the order to discontinue the Amiodarone was not noted by the nurse who received the order. The DON indicated the medication error was discovered because the nurses were discussing Resident #E's ongoing low pulses and realized the Amiodarone was still being given. The DON further indicated Resident #E's heart rate remained low, even after the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication was discontinued. She indicated she was not able to find a specific policy related to noting new physician orders. This Federal tag relates to Complaint IN00116933. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to assure sufficient supervision and assistance during a transfer, resulting in a resident being lowered to the floor. This deficiency affected 1 of 3 residents, who were reviewed for falls, in a sample of 4. (Resident #D) Findings include: On 10/5/12 at 9:00 a.m., during the orientation tour, accompanied by the DON (Director of Nursing), Resident #D was observed sitting in her room in a wheelchair. The DON indicated the resident had a recent fall and was now being transferred using a mechanical lift. The clinical record of Resident #D was reviewed on 10/5/12 at 3:30 p.m. and indicated the resident had diagnoses which included, but were not limited to, congestive heart failure, peripheral vascular disease and coronary artery disease.	F0323	1. The physician and family were notified of the residents fall and no orders were obtained. The assignment sheet was reviewed to ensure accuracy.2. All other residents have the potential to be affected. The assignment sheets for all other residents were reviewed to ensure correct information was available.3. The BNA was immediately educated on following CNA assignment sheets by the DNS on 9/27/12. All other nursing staff was educated on following CNA sheets when caring for residents on 10/9/12 by the DNS. The charge nurse will conduct rounds on all shifts to ensure staff are following CNA assignment sheets. 4. The DNS/Designee will monitor through observation that the CNAs/BNAs are following their assigmnent sheets when providing care daily on all shifts. To ensure compliance, the DNS/Designee is responsible for the completion of the transfer technique skills validation CQI tool weekly times 4 weeks, bimonthly times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING _____ B. WING 00	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Fall Care Plan, dated 6/29/12, indicated Resident #D was at risk for falls related to balance difficulties, medication use, arthritis and a history of falls. One of the Care Plan interventions indicated "Provide assistance as needed." A MDS (Minimum Data Set) Assessment, dated 9/18/12, indicated the resident required extensive assistance of two staff persons for transfers and toileting. On 9/27/12 at 3:14 p.m., Nursing Notes indicated "Resident was up in w/c (wheelchair) and requested to go to bathroom. CNA (Certified Nursing Assistant) assisted to room to take to bathroom and applied gait belt and was in process of transferring and resident stood and the (sic) unable to turn and was assisted to the floorand (sic) sat on bottom in front of w/c (wheelchair)..." The Fall Event Report, dated 9/27/12, indicated the resident had a "small open blood blister to Rt (right) side of outer knee..." The report indicated, per therapy assessment and physician's orders, the resident was to be transferred using a "hoyer lift."		of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to enusre compliance.5. Completion Date: 10/24/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 10/9/12 at 10:00 a.m., the DON was interviewed. The DON indicated, when Resident #D was lowered to the floor on 9/27/12, she required the assistance of two staff persons for transfers and this was stated on the assignment sheet. She identified BNA ("Before Nursing Assistant") #11 as involved in the incident. This nursing assistant had completed her certified nursing assistant training, but had not yet passed the certification skills and written exam to become certified. The DON indicated she re-educated the BNA regarding the need to follow the CNA assignment sheet. The CNA Resident Care Procedures, completed by BNA #11, were dated 9/5/12 through 9/11/12 and indicated "When beginning and ending a procedure, the learner must perform specific steps to ensure...safety...and Comfort... 1. ASK NURSE ABOUT RESIDENT'S NEEDS, ABILITIES AND LIMITATIONS..." This Federal tag relates to Complaint IN00116933. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interviews and record review, the facility failed to prevent a significant medication error, which occurred because a nurse failed to verify the identity of a resident before administering a medication. This deficiency affected 1 of 2 residents, whose medication errors were reviewed, in a sample of 4 (Resident #B). Findings include: A. On 10/5/12 at 9:00 a.m., during the orientation tour, accompanied by the DON (Director of Nursing), Resident #B was observed lying in bed. The DON indicated, in August 2012, Resident #B was mistakenly given Klonopin (a medication used to treat seizures and behaviors) and had been sent to the hospital. The clinical record of Resident #B was reviewed on 10/5/12 at 10:00 a.m. and indicated the resident was admitted to the facility on 6/29/12, with diagnoses which included, but were not limited to, left hip fracture, malnutrition, failure to thrive, and Alzheimer's disease.	F0333	1. The resident in question was evaluated by ER per doctors orders. The Mar was reviewed to ensure all orders were accurate and that pictures were present for identification purposes. No concerns noted at that time. 2. No other residents had been affected. All other residents have the potential to be affected. The nurse in question was immediately suspended pending an investigaiton. The nurse received additional training and had her skills validated by the DNS prior to working independently. All nurses will have extended orientation on each hall and will have a skills validation prior to working independently.3. The DNS/Designee will monitor that all nurses will have proper orientation on each hall and will complete skills validations prior to working independently. This monitoring will continue for each new hire indefinitely. 4. Charge nurse will provide monitoring of med pass to new nurses to ensure med administration is completed as ordered. To ensure compliance, the DNS/Designee is responsible for the competion of the skills validation CQI tool for all new nurses monthly times 6 months. If PRN nurses, skills	10/24/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 8/15/12 at 9:46 p.m., Nursing Notes indicated "resident received wrong medication at 4:35 p.m..." The note indicated the Physician was notified and Resident #B was sent to the Emergency Room for evaluation. The Transfer Form, dated 8/15/12, indicated "Unresponsive. Staff assisted the resident to get up for dinner and the resident was alert and responding. The resident was sitting by the nurses station 15 min (minutes) later and was noted to be unresponsive to verbal and pain stimuli." The Hospital History, dated 8/15/12, indicated "...Apparently, in the nursing home accidentally (sic) she was given a dose of Klonopin by a nurse. After that (sic) she started becoming very drowsy and sleepy and became pretty much unresponsive..." The History indicated the resident was admitted to the Hospital with the following diagnoses: 1. Change in mental status/obtundation secondary to accidental overdose on Klonopin; 2. Melena with anemia; 3. Alzheimer dementia, advanced. The Census Report indicated the resident was readmitted to the facility		validation will be conducted prior to working the 1st shift. If 95% threshold is not achieved an action plan will be developed.5. Completion Date: 10/24/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 8/18/12 at 12:00 p.m. On 10/5/12 at 3:00 p.m., RN #10, who mistakenly administered the Klonopin, was interviewed. RN #10 indicated she was being oriented at the time of the medication error. She indicated she trained on the 300 Hall for three days and it was her first day of training on the 200 Hall. She indicated, RN #20, who was orienting her, was at the desk noting orders and she asked RN #20 if it would be ok for her to start passing medication on the 200 Hall. RN #10 indicated, after she administered the Klonopin, she looked carefully at the Medication Administration Record and realized she had given the Klonopin to a resident in the wrong room. On 10/9/12 at 12:00 p.m., RN #20, who was orienting RN #10 at the time of the medication error, was interviewed. RN #20 indicated she was noting new orders and RN #10 wanted to do the medication pass on her own. RN #20 indicated Resident #B was by the medication cart, was not acting right and when she called Resident #B's name, RN #10 realized she had given Resident #B another resident's Klonopin.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	RN #20 indicated, after the medication error , she took over administering the medications on the 200 Hall. RN #20 indicated RN #10 did not look closely at the pictures in the medication book and did not verify the room number before she gave the Klonopin. On 10/9/12 at 12:35 p.m., the Corporate Nurse indicated RN #10 was working independently before her skill check offs were completed. The Corporate Nurse indicated, although not written, it was the policy of the facility, for nursing skill validations to be completed before new nurses were permitted to work independently. On 10/9/12 at 12:45 p.m., the DON indicated, after the medication error, RN #10 was suspended, received additional training and had her skills validated before she was permitted to work independently. The DON indicated the medication error was reported to the ISDH (Indiana State Department of Health). The Medication Pass Procedure, dated 7/2011, provided by the DON, indicated, in part, "...Verify correct resident..." The Medication Pass Procedure Skill			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	10/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Validation was signed by RN #10 and co-signed by the ADON (Assistant Director of Nursing) on 8/21/12, six days after the medication error. This Federal tag relates to Complaint IN00116933. 3.1-25(b)(9) 3.1-48(c)(2)			